HEALTH HISTORY

(PLEASE PRINT)

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TODAY'S DATE ____/____/____

PATIENT'S NAME			SEX	AGE	BIRTH DATE	SOC. SEC. #	
PATIENT'S ADDRESS	CITY	STATE	ZIP		HOME#		CELL #
PHYSICIAN'S NAME	DENTIST'S NAME					ORTHODONTIST'S NAME	
(PRIMARY INS.) POLICY HOLDER'S NAME	SEX	BIRTH DATE	SOC. SEC. #			RELATIONSHIP TO PATIENT	
NAME OF DENTAL INS:	NAME OF MEDICAL INS:		EMPLOYER NAME			BUS. #	
(SECONDARY INS.) POLICY HOLDER'S NAME	SEX	BIRTH DATE	SOC. SEC. #			RELATIONSHIP TO PATIENT	
NAME OF DENTAL INS:	NAME OF MEDICAL INS:		EMPLOYER NAME			BUS. #	
REASON FOR TODAY'S VISIT			FAMILY MEMBER'S WHO HAVE BEEN PATIENT'S HERE				

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N) ALL RESPONSES ARE KEPT CONFIDENTIAL

1. ARE YOU IN GOOD HEALTH? Y N
2. HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR? Y N
3. DATE OF LAST PHYSICAL EXAM? _____ Y N
4. ARE YOU NOW UNDER A PHYSICIAN'S CARE FOR A PARTICULAR PROBLEM? Y N
5. HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS OR HOSPITALIZATIONS? IF SO, DESCRIBE:_____ _____ Y N
6. HAVE YOU HAD ANY ADVERSE EFFECTS FROM DENTAL TREATMENT? Y N
7. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE? Y N
   - B. CONGENITAL HEART DISEASE? Y N
   - C. CARDIOVASCULAR DISEASE (HEART TROUBLE, HEART ATTACK, HEART MURMUR, CORONARY ARTERY DISEASE, HIGH BLOOD PRESSURE, STROKE, PALPITATIONS, HEART SURGERY, PACEMAKER)? Y N
   - D. LUNG DISEASE (ASTHMA, EMPHYSEMA, CHRONIC COUGH, BRONCHITIS, PNEUMONIA, TUBERCULOSIS, SHORTNESS OF BREATH, CHEST PAIN SEVERE COUGHING)? Y N
   - E. SEIZURES, CONVULSIONS, EPILEPSY, FAINTING, PSYCHIATRIC TREATMENT, DIZZINESS, NERVOUS DISORDER OR BREAK DOWN? Y N
   - F. BLEEDING DISORDER, ANEMIA, BLEEDING TENDENCY, BLOOD TRANSFUSION, DO YOU BRUISE EASILY? Y N
   - G. LIVER DISEASE (JAUNDICE, HEPATITIS)? Y N
   - H. KIDNEY DISEASE? Y N
   - I. DIABETES? Y N
   - J. THYROID DISEASE (GOITER)? Y N
   - K. ARTHRITIS? Y N
   - L. STOMACH ULCERS OR COLITIS? Y N
   - M. GLAUCOMA? Y N
   - N. FREQUENT OR RECURRING MOUTH SORES? Y N
   - O. IMPLANTS PLACED ANYWHERE IN YOUR BODY (HEART VALVE, HIP, KNEE)? Y N
   - P. RADIATION (X-RAY) TREATMENT FOR CANCER? Y N
   - Q. CLICKING OR POPPING OF JAW JOINT, PAIN NEAR EAR, DIFFICULTY OPENING MOUTH, GRIND OR CLENCH TEETH? Y N
   - R. SINUS OR NASAL PROBLEMS? Y N
   - S. ANY DISEASE, DRUGS OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM? Y N
   - T. RECURRENT INFECTIONS OF ANY KIND? Y N
8. ARE YOU USING OR TAKING ANY OF THE FOLLOWING:
   - A. STOMACH MEDICINES? Y N
   - B. THYROID MEDICATIONS? Y N
   - C. ANTIBIOTICS OR SULFA DRUGS? Y N
   - D. ANTICOAGULANTS (BLOOD THINNERS)? Y N
   - E. HIGH BLOOD PRESSURE MEDICINE? Y N
   - F. STEROIDS (CORTISONE, ETC.)? Y N
   - G. TRANQUILIZERS (VALIUM, ETC.)? Y N
   - H. INSULIN, DIABENESE, OR SIMILAR DRUG? Y N
   - I. DIGITALIS, INDERAL, NITROGLYCERIN, CALCIUM CHANNEL BLOCKERS, PROCARDIA OR OTHER HEART MEDICINE? Y N
   - J. ASPIRIN OR IBUPROFEN (MOTRIN, NAPROSYN, ETC.)? HOW MUCH DAILY?_____ Y N
   - K. MARIJUANA OR OTHER "STREET" DRUGS? Y N
   - L. ANTIHISTAMINES OR DECONGESTANTS (SELDANE)? Y N
   - M. ARE YOU TAKING ANY OTHER REGULAR MEDICATIONS, PILLS, OR DRUGS? IF YES PLEASE LIST: _____ Y N
8. ARE YOU ALLERGIC OR HAD A BAD REACTION TO:
   - A. LOCAL ANESTHETIC (NOVOCAINE, ETC.)? Y N
   - B. PENICILLIN, AMOXICILLIN, CEPHALOSPORIN'S OR OTHER ANTIBIOTICS? Y N
   - C. BARBITURATES, SEDATIVE, ETC.? Y N
   - D. ASPIRIN OR IBUPROFEN? Y N
   - E. CODEINE OR OTHER PAIN KILLERS? Y N
   - F. LATEX OR RUBBER PRODUCTS? Y N
   - G. OTHER ALLERGIES OR REACTIONS? IF YES PLEASE LIST: _____ Y N
9. DO SMOKE OR CHEW TOBACCO? Y N
10. DO YOU USE ALCOHOL? Y N
12. DO YOU HAVE ANY OTHER DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT? Y N
13. DO YOU WISH TO TALK TO THE DOCTOR PRIVATELY ABO ANYTHING? Y N
14. ARE YOU TAKING OR HAVE YOU EVER TAKEN BISPHOSPHONATES (FOSAMAX, ACTONEL FOR OSTEOPOROSIS, CHEMOTHERAPY FOR MULTIPLE MYELOMA, ETC.)? Y N
15. FOR WOMAN ONLY
   - A. IF YOU ARE USING ORAL CONRACEPTIVES IT IS IMPORTANT THAT YOU UNDERSTAND THAT ANTIBIOTICS AND OTHER MEDICATIONS MAY INTERF WITH THE EFFECTIVENESS OF ORAL CONTRACEPTIVES. THEREFORE, YOU WILL NEED TO USE MECHANICAL FORMS OF BIRTH CONTROL FOR ONE COMPLETE CYCLE OF BIRTH CONTROL PILLS AFTER THE COURSE OF ANTIBIOTICS OR OTHER MEDICATIONS IS COMPLETED. PLEASE CONSULT WITH YOUR PHYSICIAN FOR FURTHER GUIDANCE.
   - B. IF YOU ARE PREGNANT, POSSIBLY PREGNANT OR TRYING TO BECOME PREGNANT, SURGERY, ANESTHETICS OR ANY OTHER MEDICATION MAY SIGNIFICANTLY HARM YOUR DEVELOPING BABY, ESPECIALLY DURING THE FIRST TRIMESTER. PLEASE ADVISE YOUR DOCTOR IF THERE IS ANY CHANCE OF YOU BEING PREGNANT!
   - C. DO YOU WISH TO HAVE A PREGNANCY TEST? Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE.

I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR

I HAVE READ MY HEALTH HISTORY _____/_____/_____ AND CONFIRM THAT IT ADEQUATELY STATES PAST AND PRESENT CONDITIONS.

DATE	PATIENT'S SIGNATURE	SIGNATURE OF PERSON COMPLETING HEALTH HISTORY	DOCTOR'S INITIALS
_____	_____	_____	_____

UPDATE ONLY:

DATE	PATIENT'S SIGNATURE	DOCTOR'S INITIALS
_____	_____	_____

LONG ISLAND ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, LLP
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CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name:_____ Date of Birth:_____/_____/_____

My personal health information is private and confidential. I understand that my doctor and his staff work hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment and to take care of other health care operations. There will be no other use and disclosure of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his staff would follow the agreed limits.

I may cancel this consent at any time by doing one of the following:

1. Signing and dating a form that my doctor and his staff can give me called "Revocation of Consent for Use and Disclosure of Health Information" or
2. Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent authorization, the use and disclosure of my personal health information or treatment. Payment and health care operations.

If I cancel this consent, my doctor and his staff do **not** have to provide any further health care serviced to me.

My doctor has a detailed document called the "Notice of Privacy Practices." It contains more information about practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this agreement. My doctor may update this "Notice." If I ask, my doctor or his staff will provide me with the most current "Notice" and the current "Notice" will always be available at my doctor's office.

My signature below indicated that I have given the chance to review a current copy of my doctor's "Notice of Privacy Practices." My signature means that I agree to allow my doctor's to use and disclose my personal health information to carry out treatment, payment, and healthcare operations.

_____ _____

Patient (Guardian) signature Date

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Due to HIPAA Laws, Long Island Oral & Maxillofacial Surgery Associates LLP is not legally permitted to release any medical or other information to anyone other than the patient, unless authorized by the patient. This would include any **family members or adults of your choice**. You do not have to list health care professionals. Any family members or adult of your choosing must be listed below in order for them to obtain any medical or other information.

☐ I, _____, hereby give permission to Long Island
(Patient's Name)

Oral & Maxillofacial Surgery Associates LLP, to release all information to:

_____

_____

OR

☐ Patient Only

_____ _____
Patient (Guardian) Signature Date

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TO ALL PATIENTS

Please be advised that when we quote a price for a surgery there is NO GUARANTEE that your insurance company will pay the remaining balance.

The first thing your insurance company tells us when we call is that a quote of benefits is NOT a guarantee of payment.

Even after your pre-determinations are approved, there is a clause that states that payment is subject to the terms and conditions of your plan and payment may not be made as stated.

Please keep in mind that all insurance plans are not that same and that you only have a certain amount of benefits per year.

We will try and collect as much as possible from your insurance, but there is always the possibility that you will have a balance due after the insurance company pays the claim.

For those without insurance, I agree to pay any fees or charges in full the day of service.

I understand that if I fail to submit payment to our office for services rendered, I will be responsible for the entire balance plus any costs which may result from collection proceedings.

_____ _____

Patient (Guardian) Signature Date

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AUTHORIZATION TO USE SIGNATURE ON FILE

Policy Holder's Name: _____

To Whom It May Concern:

******(INITIAL ALL THREE SECTIONS BELOW)******

____ I request that payment under the dental/medical insurance program be made either to me or the provider named above on any bills or services furnished to me during the effective date of this authorization.

____ I authorize the use of the word "Signature on File" in place of my signature on claim forms to authorize release of any information relating to this claim for the purpose of making payment.

____ I have read and understand the following New York State mandated Insurance Claim Fraud Notice:
Any Person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to civil and criminal penalties.

_____ _____
Patient (Guardian) Signature Date